Commentary

False Names

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A patient's unique, personal name is fundamental in medical relationships. Sometimes, patients may use false names, which obscure family, ethnic, sexual, or billing identities. The means and motivations involved—fraud, concealment, gaining financial or personal advantage, gratifying a psychic need, or changing group assignment—produce a variety of distinct clinical manifestations of false name use. These may be classified as alias, pseudonym, manipulator, fraud, psychotic, amnestic, medical factitioner, and renamed. The identification of falsely named patients enables clinicians to improve care for these types of patients. Individual cases are briefly described and a discussion of naming in society and medicine follows. This preliminary discussion may serve to fuel further refinement.

The name of a patient, basic in most medical contacts as well as in virtually every human interaction,[1] has a number of important attributes. A name indicates membership in families, ethnic groups, and gender classes. A name also provides a distinguishing indicator for filing, billing, and charting. Physicians and the medical system use these properties as a matter of course. Mechanisms by which people change their names by marriage or court action are readily dealt with by this system and by physicians.[2]

There are, however, a collection of syndromes and circumstances in which patients withhold or deny their legal names. In these cases the social, familial, or sexual identity associated with the patient's original name may be the attribute which the patient is trying to deny or obscure. Alternatively the patient may try to manipulate one or another of these attributes to achieve some change in personal identity. The patient may be consciously deceitful or may believe the name given is real in gratification of some psychic purpose. Every experienced clinician can readily recall a series of patients who have used a false name or withheld a name; in 12 years in a homeless health center, I have seen more than 100. Although these syndromes seemingly are heterogeneous, they can be grouped into 8 discrete types. The following brief case histories present these types, discuss some of the implications, and comment on the overarching circumstances of names in the medical relationship. These 8 are not necessarily the same as the John Doe syndrome described in the emergency room literature although there is some overlap.[3]

Alias

A 55-year-old man who had chronic stable angina after a bypass developed unstable angina. After attempts to retrieve old records proved unsuccessful, he reluctantly revealed that he was using an alias supplied by the federal witness protection program. The program did supply records, blinded to name, hospital, and date.

Because this patient had a reasonable fear of death if his true name were revealed, a physician should aid the patient by maintaining confidentiality from all who have no need to know of the existence of the alias. This class includes those whose use of a false name is a result of factors external to the medical system. When the system needs to reference data under the old name, ensuing difficulties affect necessary care.

Pseudonym

A 23-year-old woman registering for her first visit as "Mary Smith" had a black eye and multiple bruises on her torso. She spoke openly about her reasons for using a pseudonym: "My boyfriend did this. He said that if I went to a doctor he would do it again twice as bad."

The frightened victim of abuse might use a pseudonym when seeking medical care. A gang member joins this group when a medical institution assigns the patient a pseudonym to reduce the chances of a repeat assault. Physicians need to be alert to patterns of injury, age, or gender in trauma victims likely to use a false name. If the use of a false name is noted in the chart, the victim can later uncover the pseudonym and use the medical records to prosecute the criminals who caused the injury. Also, the use of the false name may lead to misconceptions concerning family and group identity. Because these problems occur frequently and legal issues surround the use of the false name, a body of practice concerning these issues has arisen.[4] An open attitude by clinicians, cooperation with the patient, use of a "John Doe" label or numbered samples, and an "also known

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as" code on charts and appointment books can facilitate care while leaving open a route for later use of the patient's charts in legal proceedings.

Manipulator

A 50-year-old man who had been cut on the job was given cash by his employer who instructed him to pay for his medical care without revealing his real name lest the employer's insurance rates go up. The patient's refusal to tell what industry he worked in or what might have contaminated his wounds could have compromised his care.

The difficulties in caring for manipulative patients should not be a barrier to achieving necessary objectives. These patients, in seeking to limit the clinician's access to identifying data, may be reluctant to undergo a complete examination, submit samples for testing, or pay for services. The prudent physician should note the use of a false name on the chart, offer an appropriate range of services, and give the patient an opportunity in the future to set aside the false name.

Fraud

A 22-year-old man underwent a complex hospital stay for a new onset of ulcerative colitis. On his 22nd hospital day, a frequent visitor revealed that he had loaned the patient his insurance card, which provided for 21 days of paid hospital care per year. The patient's care may have been altered by the cardholder's past medical records at that hospital.

The fraudulent patient's care is a challenge because the trust inherent in a physician-patient bond may be broken. Fraudulent patients probably are more common than their detection.[5] As our medical system increasingly evolves into a world of haves and have-nots, the financial offices will screen more intensively, thereby increasing detection of fraudulence. Drug seekers and patients with highly stigmatized conditions may practice fraud to conceal their identities or to get access to the system. The physician's ethical code requires that essential care be provided; moreover, physicians should take systemic action so that people with life-threatening illnesses, pain, or contagious conditions do not feel pressed into fraud. The physician must document fraud and cooperate with its prosecution so that the burden of payment is not shifted to honest people.

Psychotic

A 35-year-old man sought care at a homeless health center for an infected foot blister. He recorded his name as an unpronounceable glyph, which was a pair of arcane symbols drawn as a picture. The foot healed with routine care. All the resources of the homeless health center were necessary to establish the new identity and provide him access to housing, disability payments, and medications. He now lives in a secure, clean environment where similar complications have been avoided.

Cases of psychotic patients who obscure their past identities with a new name present many difficulties because medical history, genetic association, and family ties are blocked. Delusions involved with identity are common in psychiatry. Psychotic patients develop medical conditions which require care before their delusions can be removed.[6] The prudent physician should consult and cooperate with a psychiatrist in these cases and work with the courts and families, when they are known, to get substituted judgment to improve compliance.[7] With a realistic and understanding attitude the physician can increase the odds of a good outcome.

Amnestic

A 43-year-old man developed complete amnesia for all the facts of his identity. During a lengthy hospitalization, punctuated by seizures, he was identified as a traveling salesman who, deciding to break his dependency on the bezodiazapams he acquired from multiple physicians, voluntarily terminated his intake. Other causes of amnesia were ruled out.

The amnestic patient may claim no name or can fabricate a name. Amnesia, though relatively rare, has provoked a medical and lay literature out of proportion to its frequency.[8] Differentiated from dementia and delirium, amnesia has an organic cause in most cases. Because these causes vary greatly and are potentially lethal yet treatable, the amnestic patient is an exciting challenge for the clinical team. These patients, anxious to work together with the team, fit into the accepted paradigm of diagnosis and cure.[9] The long-term challenge for the clinician is to aid the patient's reintegration into his or her personality and society.

Medical Factitioner

A 38-year-old man announced his chief complaint, "I need to get my pancreas cut out," at the same homeless health center where he had been diagnosed with pancreatitis 12 years prior. He gave a history of at least 30 hospitalizations in various cities. Attempts to retrieve records revealed that he had used other names elsewhere in the prior two years. When confronted with this, he decompensated and required involuntary psychiatric commitment.

Patients with a mind-body identity discordance who use false names are the obverse of the amnestic patients in that they are a very bad fit with the medical paradigm. Their chief concern is to have a procedure for a diagnosis for which they may have fabricated exam and laboratory findings. Multiple procedures involving multiple organ systems often are completed by an obliging medical system before some clinician perceives the pattern. Some of these patients, having a totally factitious disease, are given a diagnosis of Munchhausen's syndrome.

Because the previously cited patient had found a means through alcohol use to induce organic illness, he does not meet criteria for Munchhausen's, but the patient's peripatetic behavior, his use of a false name, and his

search for an invasive procedure, do fit the pattern.[10] The greatest threat to these patients is that the medical system, seeking to comply with their cry for help, will subject them to invasive procedures, with the attendant complications. If the behavior can be explained to the patient, complications can be avoided. The use of multiple or factitious names can be a valuable clue to the problem. The medical and social ramifications of Munchhausen's are severely disabling and best addressed with psychiatric consultation.[11]

Renamed

A 40-year-old genotypic male, phenotypic female had used a name interchangeable between genders (such as Pat) for many years. She came to her neighborhood homeless health center with the request, "I need more hormones to keep from aging." She had lived for 22 years as a woman, performing as a cross dresser in a skid row nightclub and working in the sex industry. After she was advised not to use female hormones because of elevated liver enzymes, she took three birth control pills a day for the next three weeks, from packages obtained privately. She was taken to the hospital in fulminant hepatic failure and died.

The transsexual is only one type of renamed patient, although the most prominent one. Some patients use two names in two different niches, including people in the community of gender-identity bending who may have a "street name" and continue to use their given name at work and in their families. Some of these people need special care from the medical system as the result of gender-identity changes. The prudent physician will refer patients to clinics with special multi-disciplinary teams trained to care for this rare but complex type.[12] Issues will arise outside the gender change which can impact on any physician. For example, these patients frequently suffer from violence inflicted upon them and end up in the trauma system. Open acceptance of the problems among transgendered people will improve communication and patient care.[13] On the other hand, not all transgendered and renamed people use hormones or surgery.

Discussion

In surveying the diversity and complexity of the phenomenon of patients' use of false names several questions arise. Are 8 classes enough to encompass the different types of false names? Are all these classes necessary to encompass the different types? Is there any utility to identifying these phenomena together as a syndrome? Is there any unifying principle behind these classes?

Given the variables, these classes are both necessary and sufficient. Patients are pursuing different motives, using differing means and achieving various ends as they manipulate the different attributes of personal names. Concealment is a feature of aliases, the Munchhausen's variants, the fraud, and the psychotic. The other four types are open in varying degrees about the use of the pseudonym. For the four conditions which have primary psychiatric or neurologic features, namely the psychotic, the renamed, the amnestic, and the Munchhausen's, the use of the altered name, or namelessness, is inherent in the condition while the other four have factors extrinsic to their conditions which prompt the adoption of the new name. Another categorization of the 8 groups into 2 arises out of the driving motive, gainseeking. The fraud, the renamed, the medical factitioner, and the manipulator seek to gain some medical intervention while the other groups seek some non-medical advantage such as escape or group reassignment. Thus, within 3 choices—concealed or not, inherent or not, and gainseeking or not—there are 8 classes.

Differentiation is required among these categories because the different syndromes call for different responses. To cite only two obvious examples, a prospective sex-change operation would be contraindicated for a patient with Munchhausen's, and a psychotic who believed he was in the witness protection program would require completely different handling than a genuine alias user. The judicial system's interest in detecting the use of aliases and certifying the legal status of name changes is useful merely to call attention to the fact that a variety of different syndromes exist to which the clinician can be alerted. The compilation of false name syndromes with a systematic classification system presented here provides a differential diagnosis of the causes of false-name use. As soon as one of these syndromes is identified, the prudent physician is alerted to search for the presence of false names.

The unifying principle in these seemingly diverse phenomena of patients who use false names in the medical context takes us back to the fundamental purposes of names in human society. The name is the identifier, the badge of allegiance to family and group, and even a surrogate for identity itself. We are given our name at birth, and sometimes take on additional names at crucial junctions in life. We may change our name when we marry or change religious faiths. We respond to our name as a call and sign it on our contracts. Our gravestone is inscribed with our name when we die. We sign it on our contracts. When we lose credibility or damage our reputation we say we have lost it. In a medical context the patient who uses a false name is marked as having a problem in one of these aspects of human society. The clinician must be alert to the possibility of false names and able to manipulate the attributes of names as they relate to patients in order to provide comprehensive care.

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